National Governors Association High Need, High Cost Individuals Policy Academy: Inventory of Current and Prospective Medicaid and State-Funded Intervention Efforts 9-29-15

Intervention	Lead Agency	Synopsis
Medicaid predictive modeling and data analytics	DSS through medical Administrative Services Organization (ASO) CHN	• Connecticut Medicaid now maintains a fully integrated set of claims data across all categories of Medicaid services and all eligibility groups • data is housed within the Utilization & Cost Analyzer (UCA) system, an analytical and data discovery tool that includes Medicaid claims, member eligibility, and provider data • UCA enables assessment of medical cost and utilization trends in various cuts of the claims, member eligibility and provider data with multiple layers of drillable investigative analysis, down to the claim, member and provider level • CHN also uses DSTHS CareAnalyzer® to determine current and predicted risk, assess disease prevalence and identify needs of high need, high cost individuals (e.g. those with gaps in care, poor pharmacy adherence) • CareAnalyzer is a web-based tool that combines elements of patient risk, care opportunities and provider performance and is updated on a monthly basis with Medicaid claims, member eligibility, provider data and lab results • CareAnalyzer® includes two main components: quality measures including NCQA HEDIS® certified measures and the Johns Hopkins ACG® (Adjusted Clinical Group) system • CHN uses the HEDIS® measures within CareAnalyzer® to monitor performance throughout the year on key measures. Performance is monitored at the population level, by setting (e.g., PCMH, hospital clinic, and non-PCMH community practice) and at the individual practice level. The HEDIS measures also allow CHN to identify individual members • CareAnalyzer® also contains a series of reports designed to provide information on provider effectiveness (quality of care) and provider efficiency (cost of care) – these reports are shared with primary care practices for their attributed members.
Population-specific Medicaid predictive modeling and data analytics – special populations	DSS through medical Administrative Services Organization (ASO) CHN	• DSS works with CHN to identify a range of population-specific targets, some of which include super utilizers. • These include women with high risk pregnancies, individuals with sickle cell disease, and individuals with chronic pain. • Additionally,

Population-specific Medicaid predictive modeling and data analytics – long-term services and supports (LTSS)	DSS through the University of Connecticut (UConn) Center on Aging	• DSS is the lead agency for the statewide Long-Term Services and Supports (LTSS) Rebalancing Initiative. • The UConn Center on Aging has since inception of Connecticut LTSS rebalancing efforts studied diverse aspects of individual (e.g. health, life satisfaction, community engagement) as well as systemic (budgetary, provider capacity, etc.) impact. • An important aspect of UConn's analysis is to examine the incidence of ED use and readmission among recipients of LTSS.

Population-specific Medicaid predictive modeling and data analytics – adults with behavioral health conditions	DMHAS with behavioral health ASO Value Options	• DMHAS will continue to work with the BH ASO to continue to develop our understanding of ED utilization, both by analyzing the Medicaid members who have the highest levels of use of ED services, especially those with episodic and persistent patterns noted in 2014 PT, and by comparing and contrasting the ED utilization at individual hospitals. The analyses will deepen our understanding of factors that contribute to members' ED use, who to target and how to best intervene, and also to determine if there are best practices and/or outliers among the hospitals. Specifically:
		  • Include a predictive analysis of ED Frequent visitors using the definitions developed during the 2014 PTDevelop the predictive model beginning with those variables identified as empirically related to ED Frequent use in prior analyses (e.g. 2013 and 2014 PTs).
		  • Test this model against alternative data sets (e.g. different years or split-half samples)
		  • Develop a risk stratification score for each Medicaid member and refresh the list every 90 days
		  • Determine the predictive validity of the assigned risk score
		  • If there is modest predictive validity, outline a methodology to allow ED providers to gain timely access to risk scores for use in triage, disposition, and follow-up with member

Population-specific Medicaid predictive modeling and data analytics – DCF-involved children experiencing discharge delay	DCF with behavioral health ASO Value Options	• DCF has over the last three years partnered with the Medical behavioral health ASO to assess needs of its beneficiaries using Medicaid claims as well as DCF data. • The first two years of analysis show that the majority of children who repeatedly use the Emergency Department are DCF involved, through child welfare, voluntary services, or juvenile justice. Further, the data illustrates that many of these children have co-occurring medical conditions including obesity, diabetes, hypertension, and asthma.

Population-specific Medicaid predictive modeling and data analytics – corrections involved individuals	DOC	• DOC is in the early stages of implementing a new Electronic Health Record system that will better memorialize and enable analysis of the health needs of its population. More than 95% are Medicaid eligible. • DOC is also interested in more comprehensively assessing the needs of individuals post-incarceration, but does not presently have good data about these individuals. Eighty percent of these individuals have a substance use disorder and many have mental health and chronic disease issues.
Medical Administrative Services Organization (ASO) Intensive Care Management (ICM)	DSS	• CHN utilizes a stratification methodology to identify members who presently frequent the emergency department (ED) for primary care and non-urgent conditions as well as those at risk of future use of acute care services • High risk members are defined as those who have claims data of seven (7) or more ED visits in a rolling year; members with twenty (20) or more ED visits in a rolling year are defined as ED Super Users and are considered highest risk. • ICM focuses on high risk members with multiple co-morbid, advanced, interrelated, chronic and/or behavioral (psychiatric and/or substance abuse) conditions. These members frequently exhibit instability in health status due to fragmented care among multiple providers, episodes or exacerbations and/or complications and impaired social, economic and material resources and tend to have higher ED utilization. • Many of these members are homeless and are in need of coordinated housing and access to health homes. Individuals with multiple chronic conditions benefit from an integrated plan of care that incorporates behavioral and non-medical supportive services.
Behavioral Health ASO ICM	DSS, DMHAS, DCF	• Value Options used claims and other data to identify the five Connecticut hospitals that were associated with the greatest number of Medicaid high utilizers. • ValueOptions then designed and implemented a multi-pronged approach to reduce the inappropriate use of the emergency department for individuals with behavioral health conditions. • This approach includes 1) assigning ICM to individuals who have visited the ED, with a primary or secondary behavioral health diagnosis, seven or more times in the six months prior to participation in ICM; 2) assigning peer specialists to members who could benefit from that support; and 3) dedicating a Regional Network Manager to help facilitate all-provider meetings to address the clinical and social

		support needs of the involved individuals. • These provider meetings are multi-disciplinary and include, but are not limited to representatives from housing organizations, substance abuse and mental health providers, shelters, Federally Qualified Health Centers, and staff from the respective EDs.
Dental Health ASO ICM	DSS	• Care Coordination and Case Management services are provided through a team of seven Dental Health Care Specialists (DHCS) that are unique to Connecticut; six who cover specific regions and one who works with clients who have Special Health Care Needs (SCSHCN). • Professionals or community agencies can refer identified clients to the CTDHP for care coordination services. • The services include management of care and coordination of services between dental and medical specialties as well as the coordination of other Medicaid benefits. • Special outreach initiatives are focused on educating the population about oral health care and include prenatal clients, children who do not have routine care, clients with special health care needs, sealant placement to prevent future decay and improved dietary choices including encouraging responsible behaviors.
DMHAS Interventions		• DMHAS is working on a pilot project looking at frequent users in 6 month periods to see if there is episodic frequency. About 30 percent had high utilization in pre- and post-study period. _
DCF Interventions		• DCF participated in a large, multi-disciplinary group led by OPM that examined the needs of children with behavioral health conditions and/or autism spectrum disorder who experience discharge delay while situated in the ED. This group has developed an extensive set of recommendations to better address this challenge, including increasing crisis stabilization and emergency mobile crisis resources, expanding community-based behavioral health services, developing a Care Management Entity, and developing a continuum of specialized services for youth with ASD (in collaboration with DSS and DDS). • Using Medicaid claims data to identify DCF involved youth with repeat ED visits, DCF staff have begun to develop crisis plans to help divert targeted youth from additional, unnecessary ED visits.
Enabling legislation in support of paramedicine	DSS with DPH	• In the 2015 session, the Connecticut legislature directed DSS and its sister Department of Public Health to partner with ambulance providers to study and develop plans for implementation of a paramedicine program.

		• This will include review of 1) the health care needs of persons who access the 9-1-1 system when the emergency department is not the most appropriate place for such persons to receive such services; 2) the feasibility of providing short-term follow-up home visits for persons who have recently been discharged from a hospital until such time as other health care providers are able to provide home visits or other follow-up health care services; 3) the need and feasibility of emergency medical services personnel to provide home visits to persons who are at a high risk of being frequent, repeat users of the emergency department to help such persons manage their chronic diseases and adhere to medication plans; 4) the need to provide ancillary primary care services for populations in areas where there is a high utilization of the 9-1-1 system for nonemergency situations; 5) current best practices in mobile integrated health care; 6) scope of practice for emergency medical services personnel; 7) practice guidelines for community-based health care services; and 8) Medicaid authority under which community-based health care services may be covered.
Utah Safe to Wait initiative	Utah Medicaid	• Provided information and education to Medicaid beneficiaries about options to using the ED, connected beneficiaries to primary care and disseminated to them a list of urgent care clinics throughout the state. • For more information, see this link: http://health.utah.gov/opha/publications/hsu/10Jun_MedicaidER.pdf http://health.utah.gov/opha/publications/hsu/10Jun_MedicaidER.pdf
Connecticut hospital-based interventions: Middlesex Hospital Community Care Team	Middlesex Hospital , River Valley Services, Gilead Community Services Inc., Connecticut Valley Hospital (Merritt Hall), Rushford Center Inc., Community Health Center (Middletown), Advanced Behavioral Health, Value Options Connecticut, and St. Vincent De Paul	• The Community Care Team offers high need, high cost patients a coordinated intervention. Team members, including the partners and a health promotion advocate, meet on a weekly basis to review cases, uncover service gaps, and develop individualized care plans. As the patient travels through the continuum of care, he or she is linked to appropriate services. • Outcomes for patients include reduction in the use of the ED, maintained sobriety, mental health stabilization, improved access to care, reduced homelessness, supportive and stable housing, workforce re-entry, reconnection with family, educational pursuits, and the feelings of self-worth and respect that come with improved quality of life. • For more information, see this May, 2015 Facts at a Glance: http://cceh.org/wp-content/uploads/2015/06/Middlesex-County-CCT-Fact-Sheet-5_13_15.pdf

Transitions Clinic Network	Cornell Scott Hill Health Center and Yale University School of Medicine Primary Care Clinic	• Initially funded through a CMS innovative practice grant, the Transitions Clinic Network is committed to caring for patients leaving the criminal justice system. Patients are seen within two weeks of release and are provided with multiple supports besides medical, mental health, and substance use care. The clinic model makes effective use of Community Health Workers to assure community integration and medical follow up as well as vocational and housing support. The Transitions Clinic Model has been shown to both reduce recidivism and reduce health care costs by reducing emergency room visits. • For more information please refer to the website: www.transitionsclinic.org